COBRA Continuation Coverage Election Notice

This notice contains important information about your right to continue your health care coverage in the Public Employees Benefits Board (PEBB) program.

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your PEBB health care coverage. If you have any questions concerning the information in this notice or your rights to coverage, you should contact the Health Care Authority (HCA) at 1-800-200-1004 or P.O. Box 42684, Olympia, Washington 98504-2684.

If you do not elect to continue your health care coverage by completing the enclosed form and returning it to the HCA, your PEBB coverage will end on the last day of the month you cease to be eligible under PEBB rules. Refer to the enclosed rate sheet to find the monthly premium for COBRA continuation coverage.

Because of the event that will end your employer-sponsored coverage, you, your covered spouse, and/or covered dependent children are entitled to continue your health care coverage for up to the maximum length of COBRA coverage shown in the chart below. If you elect to continue your PEBB coverage under COBRA, your continuation coverage will be effective the first day of the month following the date you are no longer eligible under PEBB rules and can last until the maximum length of COBRA coverage shown in the chart below.

If you have left employment due to a disability, COBRA coverage may not be the only option available to you. Please contact the HCA for additional information.

Note: For dependents who are not qualified beneficiaries for COBRA continuation coverage (i.e., qualified same-sex domestic partners and their children), PEBB offers an Extension of Coverage similar to COBRA. The Extension of Coverage time periods are the same as COBRA. For more information, call PEBB Benefit Services at 1-800-200-1004.

Qualifying event	Qualified beneficiaries	Maximum length of COBRA coverage
Employee hours are reduced to the extent of losing eligibility	Employee and covered dependents	18 months*
Employee terminates employment for reasons other than gross misconduct	Employee and covered dependents	18 months*
Employee becomes enrolled in Medicare (Part A, Part B, or both)	Covered dependents	36 months
Death of employee**	Covered dependents	36 months
Divorce or legal separation from employee	Covered dependents	36 months
Child is no longer eligible	Covered child(ren)	36 months

* COBRA continuation coverage may be extended an additional 11 months in some instances. See "How can you extend the length of continuation coverage?" on page 2 of this notice.

**In the event of the employee's death, surviving dependents may be eligible to continue coverage under a retiree plan. Contact PEBB for more information.

Important - To elect continuation coverage you MUST complete the enclosed form and return it to the Health Care Authority (HCA). You may mail it to the address shown on the *COBRA Continuation Coverage Election* form. The completed form must be received within 60 days of the date you receive notice of your right to COBRA continuation coverage. If you do not submit the completed form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the following pages.

Important information about your COBRA continuation coverage rights

What is continuation coverage?
Federal law requires that most group health plans (including PEBB) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee, a covered spouse, and covered dependent children.

Continuation coverage is the same PEBB coverage that is available to other PEBB participants. Each qualified beneficiary who elects continuation coverage will have the same rights under PEBB as other participants or beneficiaries covered under PEBB, including open enrollment. Specific information describing continuation coverage can be found in your plan's certificate of coverage (COC) which can be obtained from your medical and dental plans.

How long will continuation coverage last?
Continuation coverage will be terminated before the end of the maximum period (as shown in the previous chart) when any of the following occurs:

1. The plan terminates.
2. COBRA premiums are not paid in a timely manner.
3. You or an enrolled dependent become covered under another group health plan after the date of the COBRA election. However, if the other plan contains a pre-existing condition exclusion or limitation that applies to the person covered, you may continue your COBRA coverage until the pre-existing condition waiting period ends in the other plan.
4. You materially misrepresent or provide fraudulent information to be used in determining eligibility.
5. You send a written request to terminate coverage.

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the HCA of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the HCA of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries shown on the chart on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the HCA of that fact within 30 days of SSA's determination.

Second qualifying event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage under PEBB rules. You must notify the HCA within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary shown on the chart on the first page of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children. A qualified beneficiary must elect coverage with 60 days of being notified of his or her right to COBRA

continuation coverage. Failure to do so will result in loss of the right to elect continuation coverage under PEBB. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed on the chart on the first page. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

You and your dependents are not allowed to change medical or dental plans at the time you continue your benefits under COBRA. You will be allowed to change plans only during an open enrollment period or when you move out of your plan's service area. If you elected to waive PEBB coverage as an eligible employee, you may re-enroll in a PEBB plan at the time you continue your benefits under COBRA.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage is shown in the *Monthly PEBB COBRA Rates* included in this packet.

When and how must payment for continuation coverage be made?

First payment for continuation coverage
If you elect continuation coverage, you do not have to send any payment for continuation coverage with the *COBRA Continuation Coverage Election* form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the form is postmarked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under PEBB.

Your first payment must cover the cost of continuation coverage from the time your coverage under PEBB would have otherwise terminated, up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. Refer to the *Monthly PEBB COBRA Rates* in this packet to confirm the correct amount of your first payment.

Your payments for continuation coverage should be sent to:

Washington State Health Care Authority
P. O. Box 42695
Olympia, WA 98504-2695

Make checks payable to the Washington State Treasurer.

Monthly payments for continuation coverage
After you make your first payment for continuation coverage, you will receive monthly invoices and will be required to pay for each subsequent month of continuation coverage. Under PEBB, these payments for continuation coverage are due on the 15th of each month.

Grace periods for monthly payments
Although monthly payments are due on the date shown above, you will be given a grace period of 30 days to make each payment. Your continuation coverage will be provided for each coverage period as long as payment is made before the end of the grace period for that payment. If you fail to make a payment before the end of the grace period for that month of coverage, you will lose all rights to continuation coverage under PEBB.

Can you elect other health coverage besides continuation coverage?

When your group health coverage ends under PEBB, you have the right to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under PEBB. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

Contact your medical plan for detailed benefits information. Application for conversion coverage must be made within 31 days from the date the PEBB coverage ends. Uniform Medical Plan enrollees must apply through the HCA. Enrollees in all other PEBB-sponsored plans must apply directly to their medical plan. If you or your dependents choose not to enroll in a conversion plan, your COBRA group coverage will end when your COBRA continuation period expires.

For more information

This notice does not fully describe continuation coverage or other rights under PEBB. More information about continuation coverage and your rights under PEBB is provided in your medical and dental plan COCs available from your health plans.

You may find the PEBB's existing laws in chapter 41.05 of the Revised Code of Washington (RCW), and rules in chapters 182-08 and 182-12 of the Washington Administrative Code (WAC). These are available on the Office of the Code Reviser's Web site at **slc.leg.wa.gov**, or by calling 360-786-6777 (RCWs) or 360-786-6698 (WACs).

For more information about your COBRA rights, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Where to go for assistance

Within your agency or higher-education institution: The personnel, payroll, or benefits office in your own agency or higher-education institution can assist you with forms and answer general questions about eligibility for COBRA benefits.

Within the Health Care Authority: If you are unable to get the information you need from your agency or higher-education institution, the HCA's benefits specialists can help answer your questions about HCA and PEBB policies, plan eligibility and enrollment, COBRA continuation, or conversion of coverage.

Address changes

In order to protect your family's rights, you should keep the HCA informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the HCA.

Health plan comparisons in this document are based on information believed accurate and current, but be sure to confirm information before making decisions.

To obtain this publication in another format (such as Braille or audio), contact our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), please call 360-923-2701 or toll-free 1-888-923-5622.

Washington State Health Care Authority
Public Employees Benefits Board

Monthly PEBB COBRA Rates

Effective January 1, 2004

Special Requirements

1. To qualify for the Medicare rate, you must be enrolled in both Parts A and B of Medicare.
2. Medicare-enrolled subscribers in Group Health Cooperative's Medicare+Choice plan, Kaiser Senior Advantage, and PacifiCare Secure Horizons plans must agree to and sign the *Medicare+Choice Plan Election Form* to qualify for the lower Medicare rate. For more information on these requirements, please contact your health plan's customer service department.

Medical Plans

Subscribers not eligible for Medicare (or enrolled in Part A only):	Community Health Plan of Washington	Group Health Cooperative	Group Health Options	Kaiser Foundation Health Plan of the Northwest	PacifiCare of Washington, Inc.	RegenceCare	Uniform Medical Plan Preferred Provider Organization	UMP Neighborhood
Subscriber Only	$341.54	$343.54	$361.77	$332.63	$ 381.31	$ 382.20	$329.30	$319.38
Subscriber & Spouse	679.16	683.16	719.63	661.35	758.70	760.49	654.68	634.85
Subscriber & Child(ren)	594.75	598.25	630.17	579.17	664.35	665.92	573.33	555.98
Full Family	932.37	937.87	988.02	907.88	1,041.74	1,044.20	898.71	871.45
Subscribers enrolled in Parts A & B of Medicare:								
Subscriber Only	316.77	253.19	320.74	207.56	247.23	350.56	232.84	232.84
Subscriber & Spouse (1 eligible)	654.39	592.81	678.60	536.28	624.62	728.85	558.22	548.30
Subscriber & Spouse (2 eligible)	629.63	502.47	637.56	411.20	490.54	697.21	461.75	461.75
Subscriber & Child(ren)	569.99	507.91	589.13	454.09	530.27	634.28	476.87	469.43
Subscriber & Child(ren) (2 eligible)	629.63	502.47	637.56	411.20	490.54	697.21	461.75	461.75
Full Family (1 eligible)	907.61	847.53	946.99	782.81	907.66	1,012.56	802.25	784.90
Full Family (2 eligible)	882.84	757.19	905.95	657.74	773.58	980.92	705.79	698.35
Full Family (3 eligible)	942.48	751.75	954.38	614.85	733.85	1,043.86	690.67	690.67

Dental Plans with Medical Plan	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
Subscriber Only	$33.03	$ 34.65	$ 36.09
Subscriber & Spouse	66.06	69.30	72.18
Subscriber & Child(ren)	66.06	69.30	72.18
Full Family	99.08	103.95	108.26

Dental Plans Dental Only	DeltaCare, administered by Washington Dental Service	Regence BlueShield Columbia Dental Plan	Uniform Dental Plan
Subscriber Only	$ 36.94	$ 38.57	$ 40.00
Subscriber & Spouse	69.97	73.22	76.09
Subscriber & Child(ren)	69.97	73.22	76.09
Full Family	103.00	107.87	112.18

HCA 50-265R (10/03)
For information, contact the Health Care Authority at 1-800-200-1004.

Public Employees Benefits Board (PEBB)

2004 COBRA Continuation Coverage Election

- Type or print clearly in black ink. Inaccurate, incomplete, or illegible information may delay coverage.
- List all eligible family members and indicate their enrollment status.
- Make checks payable to the State Treasurer.

Employee Information ONLY	Employee name	
	Employee social security number	Date employer coverage ended (mm/dd/yyyy)

Section 1: SUBSCRIBER INFORMATION

Social security number	Sex ❑ M ❑ F	Last name	First name	Middle initial
Address				Apt./unit number
City	State	ZIP Code	County of residence	
Date of birth (mm/dd/yyyy)	Work phone number (including area code) ( )	Home phone number (including area code) ( )		

The medical plans marked with an asterisk (*) in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. Contact your plan for code. ➡ Physician or clinic code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason:** _____ **Date of event** _____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date _____

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, please send a copy of your Medicare card(s) along with this form.

Section 2: SPOUSE INFORMATION

List all eligible family members and indicate their enrollment status.

Social security number	Date of marriage (mm/dd/yyyy)	Physician name or clinic code	Sex ❑ M ❑ F
Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)
Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason:** ❑ Widowed ❑ Divorced ❑ Other _____ **Date of event** _____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date _____

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, please send a copy of your Medicare card(s) along with this form.

Section 3: FAMILY MEMBER INFORMATION

(Such as child, grandchild, etc.) ***Use additional forms for more members.*** *List all eligible family members and indicate their enrollment status.*

A

Relationship to subscriber	Social security number	Physician or clinic code	Disabled? ❑ Student? *Check only if age 20 or older.*	Sex ❑ M ❑ F

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason:** _____ **Date of event** _____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date _____

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, please send a copy of your Medicare card(s) along with this form.

B

Relationship to subscriber	Social security number	Physician or clinic code	Disabled? ❑ Student? *Check only if age 20 or older.*	Sex ❑ M ❑ F

Last Name	First Name	Middle initial	Date of birth (mm/dd/yyyy)

Address (if different from subscriber)	City	State	ZIP Code

Select coverage you wish to continue: ❑ Medical/Dental ❑ Medical only ❑ Dental only

❑ **Cancel all coverage** **Reason:** _____ **Date of event** _____

Are you disabled under Title II (OASDI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you disabled under Title XVI (SSI) of the Social Security Act? ❑ Yes ❑ No Effective date _____

Are you covered by another group medical or dental plan? ❑ Yes ❑ No Effective date _____

Are you enrolled in Part(s) A and/or B of Medicare? Part A (hospital) ❑ Yes ❑ No Effective date _____

Part B (medical) ❑ Yes ❑ No Effective date _____

Note: If you are enrolled in Medicare Part(s) A and/or B, please send a copy of your Medicare card(s) along with this form.

Section 4: MEDICAL PLAN SELECTION

(Check only one.)

- ❑ Community Health Plan of Washington*
- ❑ Group Health Cooperative*
- ❑ Group Health Options, Inc.*
- ❑ Kaiser Foundation Health Plan of the Northwest
- ❑ PacifiCare of Washington, Inc.*
- ❑ RegenceCare*
- ❑ Uniform Medical Plan Preferred Provider Organization
- ❑ UMP Neighborhood (current members only)

** These plans require the physician or clinic code of your selected primary care provider. You may find the code in the provider directory on our Web site or by calling the plan.*

Section 5: DENTAL PLAN SELECTION

(Check only one.)

Preferred Provider Organization

❑ Uniform Dental Plan (Group #3000)
(may receive services *from any provider*)

Managed Care Plans

❑ DeltaCare (Group #3100)
Dentist name _____
(must receive services from *DeltaCare provider*)

❑ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Section 6: SIGNATURE (Required)

Insurance coverage is determined through verification of eligibility by the Washington State Health Care Authority. I declare that to the best of my knowledge and belief my family members and I are eligible for the coverage requested. This form supersedes all forms and submissions I have previously made for coverage. A premium deposit does not guarantee coverage and will be refunded if I am determined to be ineligible for coverage.

Washington State law may require disclosure of any information you submit as a public record. The HCA's Privacy Notice is available upon request by calling 360-923-2822 or online at **www.hca.wa.gov**.

Subscriber's signature _____ Date _____

Washington State Health Care Authority
Public Employees Benefits Board

Visit our Web site at www.pebb.hca.wa.gov

Please sign and date this form.

Return to: Washington State Health Care Authority,
P.O. Box 42684, Olympia, WA 98504-2684

If payment enclosed, return to:
Washington State Health Care Authority,
P.O. Box 42695, Olympia, WA 98504-2695

For Agency Use Only ❑ 18-month (Terminated or reduction in hours) ❑ 29-month (Approved disability [SSI]) ❑ 36-month (Spouse/child: loss of dependent eligibility)

Conversion of Your PEBB Group Life Policy

When you terminate your employment or retire, you are entitled to convert your Public Employees Benefits Board (PEBB)-sponsored group life insurance policy to an individual whole life policy. You may do this *without providing proof of good health* when your coverage ends or is reduced under the group plan sponsored by the PEBB. You can also convert the group life coverage on your spouse/qualified same-sex domestic partner and dependents to individual whole life policies for each covered dependent. See your PEBB life insurance booklet for further details or call a customer service representative at ReliaStar Life Insurance Company (1-866-689-6990).

To apply for conversion of your group life insurance, fill out and mail the bottom part of this form to ReliaStar Life Insurance Company. **To protect your right of conversion, this form must be postmarked no later than 31 days (if you are terminating employment) or 60 days (if you are retiring) following the date your group coverage terminates.** When your application is received by ReliaStar, you should expect to receive the company's conversion application within 15 days.

Provided that you apply on time and pay your first premium, the converted policy will take effect either 31 days (for terminating employees) or 60 days (for retiring employees) after the date of termination of your group coverage. **You are covered by the group plan during the 31-day or 60-day conversion period, as long as premiums are paid.** You will be billed directly by ReliaStar Life Insurance Company for all premium payments retroactive to the date your group term life coverage ended. In addition, the company will provide all policy service you may require directly. The Health Care Authority will not be involved.

For terminating or retiring employees of PEBB-sponsored plans

I am interested in the conversion option described in my Group Insurance Certificate. Please furnish information and the necessary forms.

Employee's name	Social security number – –	Date of birth
Spouse's/same-sex domestic partner's name (Complete only if you are interested in converting his or her insurance.)		Date of birth

Phone number	State agency or institution	**Reason for Conversion**
Address	Apt./unit number	☐ Retiring Date _____ ☐ Resigning Date _____ ☐ Other Date _____
City, county, state, and ZIP Code		If other, state reason _____
Note: If you are disabled and qualify for the waiver of premium benefit, check this box. ☐		_____

Date	Signature
	please sign printed copy

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.pebb.hca.wa.gov.

Please return to:
ReliaStar Life Insurance Company
P.O. Box 20 - Route 7325
Minneapolis, MN 55440-0020

HCA 50-540 (4/03)

Washington State Health Care Authority
Public Employees Benefits Board